

		FOR OHF USE					

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**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0039610</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>ROCKFORD HEALTHCARE CENTER</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>310 Arnold Street</u> <u>Rockford</u> <u>61108</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Winnebago</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>Linda Holtzscheiter</u> (Title) <u>Reimbursement Manager</u>	
<b>Telephone Number:</b> <u>(818) 398-7654</u> <b>Fax #</b> <u>(818) 399-0473</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Cathy Simeoni, Manager - Healthcare Consulting</u> (Firm Name & Address) <u>Kellogg &amp; Andelson, Accountancy Corporation</u> <u>16162 Beach Blvd, #308, Huntington Beach, CA 92647</u> (Telephone) <u>(714) 596-7713, fax 596-7721</u> <b>Fax #</b> ( )	
<b>IDPA ID Number:</b> <u>381923423004</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>06/07/94</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Cathy Simeoni</u> <b>Telephone Number:</b> <u>(714) 596-7713, Ext 12</u>			

Facility Name & ID Number ROCKFORD HEALTHCARE CENTER# 0039610 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 09/10/00

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	81	Intermediate (ICF)	77	29,194	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	81	TOTALS	77	29,194	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,761	405		23,166	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,761	405		23,166	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 79.35%

D. How many bed-hold days during this year were paid by Public Aid?

1 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 06/07/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 06/07/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER** # **0039610** Report Period Beginning: **01/01/00** Ending: **12/31/00****V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	138,858	18,271	37,620	194,749		194,749		194,749		1
2	Food Purchase		132,809		132,809		132,809	(41)	132,768		2
3	Housekeeping	117,084	20,997	1,274	139,355		139,355		139,355		3
4	Laundry	26,904	9,996	307	37,207		37,207		37,207		4
5	Heat and Other Utilities			45,535	45,535		45,535		45,535		5
6	Maintenance	20,959	43,940	16,427	81,326		81,326	329	81,655		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	303,805	226,013	101,163	630,981		630,981	288	631,269		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			9,600	9,600		9,600		9,600		9
10	Nursing and Medical Records	1,031,307	66,607	123,396	1,221,310		1,221,310		1,221,310		10
10a	Therapy		4,543	(7,063)	(2,520)		(2,520)		(2,520)		10a
11	Activities	41,876	6,303	2,305	50,484		50,484		50,484		11
12	Social Services	29,749	19	1,943	31,711		31,711		31,711		12
13	Nurse Aide Training	35,486			35,486		35,486		35,486		13
14	Program Transportation										14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	1,138,418	77,472	130,181	1,346,071		1,346,071		1,346,071		16
	<b>C. General Administration</b>										
17	Administrative	63,332			63,332		63,332		63,332		17
18	Directors Fees										18
19	Professional Services			9,171	9,171		9,171	11,171	20,342		19
20	Dues, Fees, Subscriptions & Promotions			2,621	2,621		2,621	210	2,831		20
21	Clerical & General Office Expenses	50,689	4,350	(63,825)	(8,786)		(8,786)	205,770	196,984		21
22	Employee Benefits & Payroll Taxes			232,045	232,045		232,045		232,045		22
23	Inservice Training & Education			801	801		801		801		23
24	Travel and Seminar			19,878	19,878		19,878	1,907	21,785		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			37,214	37,214		37,214	1,210	38,424		26
27	Other (specify):*										27
28	<b>TOTAL General Administration</b>	114,021	4,350	237,905	356,276		356,276	220,268	576,544		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,556,244	307,835	469,249	2,333,328		2,333,328	220,556	2,553,884		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**

#0039610

Report Period Beginning:

01/01/00

Ending:

12/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			(246)	(246)		(246)	146,823	146,577			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							29,917	29,917			32
33	Real Estate Taxes			24,867	24,867		24,867		24,867			33
34	Rent-Facility & Grounds							43,165	43,165			34
35	Rent-Equipment & Vehicles			171	171		171		171			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			24,792	24,792		24,792	219,905	244,697			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		4,594	7,669	12,263		12,263		12,263			39
40	Barber and Beauty Shops			687	687		687	(687)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			43,918	43,918		43,918		43,918			42
43	Other (specify):*							49,747	49,747			43
44	<b>TOTAL Special Cost Centers</b>		4,594	52,274	56,868		56,868	49,060	105,928			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,556,244	312,429	546,315	2,414,988		2,414,988	489,521	2,904,509			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**

# 0039610

Report Period Beginning: 01/01/00

Ending: 12/31/00

**VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	1	2	3	
	Amount	Refer-	OHF USE	
		ence	ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(41)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income				10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(2,833)	21		24
25 Fund Raising, Advertising and Promotional	(157)	21		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(304)	21		28
29 Other-Attach Schedule	292,694			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 289,359		\$	30

OHF USE ONLY						
48		49	50	51	52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	200,162		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 200,162		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ 489,521		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	SALES TAX	\$ (2,446)	21 1
2	SMALL BALANCE ADJUSTMENT	(399)	21 2
3	BARBER&BEAUTY SHOP	(687)	40 3
4	MISCELLANEOUS RECEIPTS	(1,480)	21 4
5	DEPRECIATION RECONCILIATION	29,654	30 5
6	FAS 121*	117,169	30 6
7	Penalties	150,523	21 7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15	* The facility re-valued their assets this year. We		15
16	have reported the historical costs of the assets		16
17	consistent with the prior years, and have ensured		17
18	that depreciation expense is reported on straight		18
19	line. This adjustment is necessary to reverse the		19
20	re-valuation of historical cost.		20
21			21
22			22
23			23
24			24
25			25
26			26
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86			86
87			87
88			88
89			89
90	Total	292,694	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**# **0039610**

Report Period Beginning:

01/01/00

Ending:

12/31/00

**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(41)	0	0	0	0	0	0	0	0	0	0	(41)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	329	0	0	0	0	0	0	0	0	0	329	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(41)</b>	<b>329</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>288</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,171	0	0	0	0	0	0	0	0	0	11,171	19
20	Fees, Subscriptions & Promotions	0	210	0	0	0	0	0	0	0	0	0	210	20
21	Clerical & General Office Expenses	143,264	62,506	0	0	0	0	0	0	0	0	0	205,770	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,907	0	0	0	0	0	0	0	0	0	1,907	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,210	0	0	0	0	0	0	0	0	0	1,210	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>143,264</b>	<b>77,004</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>220,268</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>143,223</b>	<b>77,333</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>220,556</b>	<b>29</b>

## Summary B

Facility Name & ID Number	ROCKFORD HEALTHCARE CENTER	#	0039610	Report Period Beginning:	01/01/00	Ending:	12/31/00
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## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]



Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**# **0039610**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****VII. RELATED PARTIES****A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See Attached Pg 6.1		Mariner Post Acute Network	Atlanta, GA	Bookkeeping & Management

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.** ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	\$	Mariner Post Acute Network	100.00%	\$ 0	\$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	329	329	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	11,171	11,171	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	210	210	4
5	V	21	Clerical and General Office Exp		Mariner Post Acute Network	100.00%	62,506	62,506	5
6	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	1,907	1,907	6
7	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	1,210	1,210	7
8	V	32	Interest Expense		Mariner Post Acute Network	100.00%	29,917	29,917	8
9	V	34	Rental & Leasing		Mariner Post Acute Network	100.00%	43,165	43,165	9
10	V	43	Other Expenses		Mariner Post Acute Network	100.00%	49,747	49,747	10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$ 200,162	\$ *	200,162 14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ROCKFORD HEALTHCARE CENTER # 0039610 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Not applicable								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**# **0039610**

Report Period Beginning:

**01/01/00**Ending: **12/31/00**

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Mariner Post Acute NetworkStreet Address One Ravine Dr., Suite 1500City / State / Zip Code Atlanta, GA 30346Phone Number ( 770 ) 379-8203Fax Number ( 770 ) 399-1971

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8  Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			\$ 212,153	\$		\$ 0	1
2	6	Repairs and Maintenance	Facility Costs			1,115,193			329	2
3	19	Professional Services	Facility Costs			19,156,199			11,171	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			352,775			210	4
5	21	Clerical and General Office Exp	Facility Costs			51,126,150			62,506	5
6	24	Travel and Seminar	Facility Costs			5,661,045			1,907	6
7	26	Insurance Premium	Facility Costs			9,082,939			1,210	7
8	32	Interest Expense	Facility Costs			31,744,386			29,917	8
9	34	Rental & Leasing	Facility Costs			60,829,914			43,165	9
10	43	Other Expenses	Facility Costs			8,511,848			49,747	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 187,792,602	\$		\$ 200,162	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Home Office Allocation										29,917	6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$ 29,917	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$ 29,917	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**# **0039610**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>23,351</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>23,847</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>496</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>24,371</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ _____ For 19 _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	<b>24,867</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>21,128</b>	8		
	1996	<b>23,099</b>	9		
	1997	<b>23,793</b>	10	13	FROM R. E. TAX STATEMENT FOR 1999 \$
	1998	<b>23,592</b>	11	14	PLUS APPEAL COST FROM LINE 5 \$
	1999	<b>23,351</b>	12	15	LESS REFUND FROM LINE 6 \$
				16	AMOUNT TO USE FOR RATE CALCULATION \$

**2000 Estimated Real Estate Tax Accrual = \$24,371**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

## X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 18,384

B. General Construction Type:
 Exterior
 BLOCK/BRICK
 Frame
 STEEL
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

## XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	RESIDENT CARE	72,156	1994	\$ 246,608	1
2					2
3	TOTALS	72,156		\$ 246,608	3

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	81		1994		\$ 1,128,638	\$ 32,247	35	\$ 32,247		\$ 298,173	4
5			1994		1,654,825	82,741	20	82,741		433,846	5
6											6
7											7
8											8
9	<b>Improvement Type**</b>										
10											10
11											11
12	PAVE SIDEWALKS		1996		8,196	410	20	410		1,759	12
13											13
14	ALARM SYSTEM		1994		1,200	60	20	60		381	14
15	ROOF REPLACEMENT		1995		7,800	390	20	390		2,245	15
16											16
17											17
18	METAL DOOR		1996		500	25	20	25		107	18
19	PAINTING		1996		9,500	475	20	475		2,034	19
20	BATHROOM REPAIRS		1996		2,571	129	20	129		537	20
21	ROOFING		1996		3,000	150	20	150		622	21
22	DOORS/FRAME		1996		5,050	253	20	253		1,035	22
23	KITCHEN FLOOR TILE		1996		4,460	223	20	223		828	23
24	REPAIR TILE		1997		1,470	74	20	74		249	24
25	A/C DUCT SYSTEM		1996		6,279	314	20	314		1,371	25
26	DRAPES/BEDSPREADS		1996		10,510	526	20	526		2,285	26
27	EMERGENCY GENERATOR		1998		4,200	105	20	105		315	27
28	SECURITY CAMERA		1998		1,294	33	20	33		99	28
29	WATER HEATER		1995		626	31	20	31		250	29
30	HVAC UNIT		1995		775	39	20	39		311	30
31	WATER HEATER		1995		2,594	130	20	130		1,010	31
32	WATER HEATER		1995		3,464	173	20	173		1,277	32
33	LIGHT FIXTURES		1996		1,831	92	20	92		567	33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 2,858,783	\$ 118,620		\$ 118,620	\$	\$ 749,301	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		<b>Improvement Type**</b>									
9		CURTAINS		1996	702	35	20	35		208	9
10		LIGHTING		1996	1,540	77	20	77		412	10
11		ALARM MONITOR		1997	507	25	20	25		111	11
12		PHONE SYSTEM		1997	6,394	320	20	320		1,312	12
13											13
14		ADJUSTMENT TO RECONCILE TO TRIAL BALANCE 1998				52,219			(52,219)		14
15											15
16		35 KW GENERATOR		1999	1,853	185	10	185		339	16
17		ROOF LEAKING REPAIR		1999	1,465	147	10	147		269	17
18		RPLC GEN. REGULAR ROO		1999	1,396	140	10	140		256	18
19		ELEC. WORK ON GEN/RO		1999	328	33	10	33		58	19
20		REPAIR ROOF		1999	375	38	10	38		66	20
21		ELECTRICAL HEATING		1999	5,043	336	15	336		560	21
22		ELECTRICAL REPAIRS		1999	1,169	58	20	58		92	22
23		RPR FIRE SPRINKLER S		1999	3,896	390	10	390		715	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36		TOTAL (lines 4 thru 35)			\$ 24,668	\$ 54,003		\$ 1,784	\$ (52,219)	\$ 4,398	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.



**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 271,119	\$ 26,161	\$ 26,161			\$ 113,787	37
38	Current Year Purchases	716	12	12		10	12	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 271,835	\$ 26,173	\$ 26,173			\$ 113,799	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$			\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$			\$	46

**E. Summary of Care-Related Assets**

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,401,894	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 198,796	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 146,577	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (52,219)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 867,498	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	O/H ALLOCATION 1996	\$ 4,122	\$ 206	\$ 857	52
53	O/H ALLOCATION 1997	2,035	102	342	53
54					54
55					55
56					56
57	TOTALS	\$ 6,157	\$ 308	\$ 1,199	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 171 Description: Non-Medical Equipment

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_

13. /2002 \$ \_\_\_\_\_

14. /2003 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
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**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$			\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs				0			4
5	Physician Care		visits							5
6	Dental Care		visits			100			100	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts			7,110	4,594		11,704	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached 16.1					459			459	13
14	TOTAL			\$		\$ 7,669	\$ 4,594		\$ 12,263	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 900	\$	1
2	Cash-Patient Deposits	(22,444)		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	635,384		3
4	Supply Inventory (priced at )	12,090		4
5	Short-Term Investments	716		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 626,646	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	142,958		13
14	Buildings, at Historical Cost	204,291		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	92,736		16
17	Accumulated Depreciation (book methods)	(131,723)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 308,262	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 934,908	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 155,162	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,053		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,598		31
32	Accrued Real Estate Taxes(Sch.IX-B)	24,371		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	See supplemental schedule 17.1	95,827		36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 400,011	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	See supplemental schedule 17.1	3,057,894		43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 3,057,894	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,457,905	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ (2,522,997)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 934,908	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (2,103,810)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (2,103,810)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(436,148)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (436,148)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>Intercompany Transfers</b>	<b>16,961</b>	<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$ 16,961</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (2,522,997)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,495,287	1
2	Discounts and Allowances for all Levels	(531,716)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 1,963,571	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 2	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	41	13
14	Non-Patient Meals	(886)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	17,091	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 16,246	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Vending Machine	1,480	28
28a	Miscellaneous Receipts	(2,460)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (980)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,978,839	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	630,981	31
32	Health Care	1,346,070	32
33	General Administration	356,276	33
<b>B. Capital Expense</b>			
34	Ownership	24,792	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	12,950	35
36	Provider Participation Fee	43,918	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,414,987	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(436,148)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (436,148)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**# **0039610**Report Period Beginning: **01/01/00**

Ending:

**12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,083	2,329	\$ 64,782	\$ 27.82	1
2	Assistant Director of Nursing	1,908	2,134	43,052	20.17	2
3	Registered Nurses	4,373	4,891	89,576	18.31	3
4	Licensed Practical Nurses	14,449	16,158	276,313	17.10	4
5	Nurse Aides & Orderlies	44,630	49,907	564,628	11.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,612	1,803	17,759	9.85	9
10	Activity Assistants	3,078	3,442	23,818	6.92	10
11	Social Service Workers	1,959	2,190	29,377	13.41	11
12	Dietician					12
13	Food Service Supervisor	1,589	1,776	23,496	13.23	13
14	Head Cook	6,163	6,891	49,345	7.16	14
15	Cook Helpers/Assistants	9,555	10,685	68,100	6.37	15
16	Dishwashers					16
17	Maintenance Workers	1,706	1,908	21,556	11.30	17
18	Housekeepers	14,473	16,184	120,074	7.42	18
19	Laundry	3,659	4,091	26,943	6.59	19
20	Administrator	2,143	2,396	68,434	28.56	20
21	Assistant Administrator					21
22	Other Administrative	1,915	2,141	27,210	12.71	22
23	Office Manager					23
24	Clerical	1,891	2,114	20,104	9.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,882	2,104	21,677	10.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	119,068	133,144	\$ 1,556,244 *	\$ 11.69	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	650	\$ 36,089	1-3	35
36	Medical Director	120	9,600	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	185	9,112	10-3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	90	2,305	11-3	44
45	Social Service Consultant	78	1,943	12-3	45
46	Other(specify) <u>Administrative</u>	223	12,279	21-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,346	\$ 71,328		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	715	\$ 14,820	10-3	50
51	Licensed Practical Nurses	2,606	83,348	10-3	51
52	Nurse Aides	348	13,395	10-3	52
53	TOTAL (lines 50 - 52)	3,669	\$ 111,563		53



**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

[illegible]

Facility Name & ID Number **ROCKFORD HEALTHCARE CENTER**

STATE OF ILLINOIS

# **0039610**

Report Period Beginning:

**01/01/00**

Ending:

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**12/31/00**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES  
If YES, give association name and amount. ILLINOIS HEALTHCARE ASSOC. \$3026.
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 43,918  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? YES Indicate the amount. \$ 3
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? NO  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 100  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? \_\_\_\_\_**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? NO  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES  
Attach invoices and a summary of services for all architect and appraisal fees.